ENGLISH ROAD PEDIATRICS & ADOLESCENT MEDICINE, LLC

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AUTHORIZATION FOR USE OR DISCLOSURE OF PHI

Patient Name: ________________________________ Date of Birth: ___/___/_____

Street Address: ____

City: ___________________________ State: ______________ Zip Code: _________

Daytime Phone#: (____) _____-______ Evening Phone #: (____) _____-______

Periodic Use/Disclosure:

I hereby authorize English Road Pediatrics to use or disclose my protected health information (PHI) periodically to the person/provider/organization/facility/ program(s) identified as often as necessary to fulfill the purpose identified in this document at my (patient) request:

■ Immunization Record ■ Daycare Form ■ WIC Form ■ Insurance ■ School Offficals
■ Sports Evaluation Form ■ School Health Form ■ Continuing Care ■ Second Opinion
■ Workers' Compensation ■ Entire copy of the in-/outpatient record ■ Attorneys/Legal

OTHER SPECIFIC INFORMATION AUTHORIZED:

■ Educational Information ■ Appointments ■ Progress Notes ■ Laboratory Test Results
■ Diagnostic Impression ■ Discharge Summary ■ Diagnostic Test Results ■ Treatment Plans
■ Treatment summary (include history/physical, laboratory tests & x-ray reports) ■ Assessments

I understand that:

♦ This authorization will expire two years from my last date of service visit.
♦ I may cancel this authorization at any time by submitting a written request to the English Road Pediatrics address above, except where a disclosure has already been made in reliance on my prior authorization.
♦ There may be a charge for the request of copies of medical record information.
♦ That information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
♦ My healthcare and payment for my health care will not be affected if I do not sign this form.

By signing below, I acknowledge that I have read and understand this Authorization.

______________________________________ ______________
Signature of Parent/Legal Guardian/Authorized Person **Date**

______________________________________ ______________________
Print Name of Parent/Legal Guardian/Authorized Person **Relationship** to Patient

[ ] **REFUSED** to SIGN: _____
Initial

OVER

PATIENT APPROVED CONTACTS

ON this side of the form, you are able to designate trusted, reliable individuals that *you* authorize to bring your child in when you are *un*able to attend your child's appointment with their doctor. And older patients, persons whom you don't mind us communicating with regarding you. ***NOTE*:** If you choose not to designate anyone, simply write the patient's name & date of birth below, check the box, initial & date. Thank you!

PATIENT NAME: ______________________________ Date of Birth: _____/_____/_______

☐ **NOT DESIGNATING ANYONE AT THIS TIME:** ___________ _____/____/______

INITIAL **DATE**

NOTE: If any individual other than those listed below contacts English Road Pediatrics regarding the above named patient's personal health information, he or she will be referred back to the patient. In authorizing these individuals we will also assume that there are no limitations in communications regarding the patient. This authorization will expire two years from the patient's last date of service visit.

CONTACT 1: (*please print*)

Name ______________________________ Relationship to patient _________________

Contact Number (______) ______-________ Emergency Response Person: YES / NO

CONTACT 2: (*please print*)

Name ______________________________ Relationship to patient _________________

Contact Number (______) ______-________ Emergency Response Person: YES / NO

★ **SCHOOL OFFICIALS**

Including: (*please* *initial* *all that may apply to your child*)

_____ **School Nurse** _____ **Psychologist** _____ **Teacher**

_____ **Special Education** _____ **Speech Therapist** _____ **Counselor**

_____ **Physical Therapist** _____ **Occupational Therapist**

PATIENT/Rep's SIGNATURE: ______________________________ **Date:** ____/____/_____

IF signed by Representative, describe authority to act on behalf of patient: ____

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***REMINDER:** As per FINANCIAL POLICY you've signed, regardless of legal arrangements regarding divorce situations, it is the policy of English Road Pediatrics & Adolescent Medicine that the parent or authorized individual who accompanies the child to the appointment is the responsible party for the day's co-pay in full. ***It is up to the parents* to deal with their legal obligations *amongst themselves*.**